

Instructions - Request for Participant MO HealthNet Reimbursement (IM-64)

When to use this form: For a participant to request reimbursement from MO HealthNet Division (MHD) for incorrectly denied paid medical expenses. This should only be used when retroactive coverage is authorized as part of resolving an incorrect action on behalf of the agency. Examples: a hearing decision that overturns the agency's original decision, cancel closing a case that closed in error, cancel rejecting and authorizing coverage after an application was rejected in error.

How to use this form: If a participant requests MHD reimbursement, FSD Staff may complete the form with the participant in person or over the phone. If staff are not able to complete the form with the participant, you may complete the FSD Staff sections (Sections B-E) and mail it to the participant to complete Section A.

Processing this form: If the completed form is submitted to FSD or completed with the participant by FSD Staff, a copy should be put in the participant's FSD file, comments must be made in the eligibility system for the participant's case record, and FSD staff must email the completed form to MHD at MHD.PSUReferrals@dss.mo.gov.

EXAMPLE: Mr. George called the Customer Service Center and requested MHD reimbursement for medical expenses he had before his favorable hearing decision was received. FSD Staff filled out the IM-64 form for Mr. George and submitted the form to MHD.

Staff made a comment in FAMIS system. "Mr. George's MHABD application was rejected January 2, 2020. He had a hearing on January 31, 2020. Mr. George had an emergency room visit on February 2, 2020 and he paid \$500 at the time of the visit. The favorable hearing decision was received on February 28, 2020. Mr. George requested a reimbursement from the hospital and they refused to reimburse him. Mr. George would like to request a reimbursement from MHD. IM-64 completed by phone and submitted by email to MHD.PSUReferrals@dss.mo.gov."

Instructions for Completing the IM-64 Form:

FSD Office – Enter the name and mailing address for your office.

FSD Staff – Enter your name, email, and phone number. MHD must be able to contact you if there is any confusion about the information provided.

Participant's Name – Enter the full name of the participant.

DCN – Enter the participant's DCN.

Participant's Spouse – Enter the full name of the participant's spouse, if included on the case.

DCN – Enter the spouse's DCN.

Section A:

Form Question: Did you, your spouse, or another member of your household (who is an eligible MO HealthNet participant) have any medical services during the following dates?

Date 1: In the first date field, enter the date the rejection or closing action that caused denied MO HealthNet benefits.

Date 2: In the second date field enter the date of the hearing decision, or the date the FSD staff and supervisor agree and notify the participant that an incorrect decision was made to deny benefits.

Form Question: Did you pay out of pocket for any of those medical services?

Check NO. If the participant has not paid for medical services received between the two dates discussed above, check the "NO" response. The participant should sign the form (if in person) and a copy should be put in the participant's file and a copy should be given/mailed to the participant.

STOP. No other information or action is required.

Check Yes. If the participant has paid for medical services received between the two dates discussed above, check the "YES" response. Ask the follow up question.

Form Question: Have you requested a refund from the medical provider?

Check NO. If the participant has not asked the provider for a reimbursement, they must do that first. The provider should submit the eligible medical expense to MHD for payment and then reimburse the participant. MHD reimbursement to the participant will only be for the Medicaid rate, and this is generally less than the participant actually paid. Advise the participant to keep the IM-64 for their records and that they can submit the form at a later date, if the provider is unable to reimburse them.

Check Yes. If the participant has requested reimbursement from the medical provider, but the medical provider will not reimburse them, have the participant sign and date the form. A spouse can also sign the form, if they are present. If the participant has receipts, bills, or invoices, make a copy and include them with this form. If the form is completed over the phone, on the signature line, put “completed by phone” and put the date the form was completed.

Section B:

Form Question: Has the participant been determined eligible for the above period?

Check Yes. Continue to fill out this form and then submit to MHD when complete.

Check No. If the participant is not eligible, put a copy of the form in the participant’s file. Do not submit the form to MHD if the participant is not eligible.

STOP. No other information or action is required.

NOTE: This question is to check for participants who may have discovered this form on their own, or for advocates and authorized representative groups who may fill out the form, even though the participant is not actually eligible.

Section C:

Form Question: Why did the participant’s eligibility change?

Answer: FSD Staff should include a clear and complete information as possible.

Example: Mr. George received a favorable hearing decision. Hearing date: 1/31/2020. Decision received: 2/28/2020.

Example: Ms. Garland’s MHDC closed in error as verification was received timely but was indexed incorrectly and discovered after the case closed on 2/3/2020. Agency error was discovered 3/16/2020 and corrected 3/16/2020.

Form Question: Does the participant have a spend down for any month during the period shown on page 1?

Check No. If the participant is not on spend down for any of the affected period. Go to next question.

Check Yes. If the participant is on spend down for any of the affected period. Fill in the spend down eligibility dates during the time period specified on the form, which may include one or more months. If spend down was not met, leave the month blank.

Form Question: If there were more than 12 months in the period shown on page 1, please provide additional spend down information below:

Answer: If the participant was incorrectly denied more than 12 months and have expenses for those months, list additional months here.

Section E:

Form Question: Were there any other members of the assistance group during the period shown?

Answer: Enter the name and DCN of others in the assistance group for multiple person cases. List ONLY those members who were eligible for MO HealthNet coverage.

STOP! Put a copy in the participant’s file. Send the completed form to the MHD.